

DAVIS (E.D.P.)

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FROM

THE MEDICAL NEWS,

July 8, 1893.



[Reprinted from *THE MEDICAL NEWS*, July 8, 1893.]

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IF one were asked the meaning of the word "scientific," a proper definition would be found in a phrase indicating the possession and dissemination of knowledge. A scientific journal is one that contains and disseminates knowledge of the subject of which it treats. Modern medicine is a science in so far as it contains valuable knowledge concerning human life and disease, and scientific obstetrics is the theory and practice of this branch of medicine, characterized by accurate knowledge.

In this one point of the possession or absence of accurate knowledge rests the difference between the obstetric practice common in the United States twenty-five years ago and the theory and practice taught at the present day. Impressed with the ability of nature to deal successfully with the emergencies of labor, the practitioner who attended obstetric cases has been wont to comfort himself with the axiom that labor is a natural process, of

¹ Read before the Section on Obstetrics, American Medical Association, Milwaukee, June, 1893.



which he need not seek to ascertain too minutely the details. The condition of pregnancy he regarded as naturally normal, and hence without especial tendency to disease. The lying-in period was to him a natural stage in the life of the individual, and required at his hands no especial scrutiny. An accurate diagnosis as to the factors present in a given labor was rarely made, unless some serious emergency arose.

There have been many reasons for this condition of affairs. The comparatively recent discovery of anesthetics placed at the disposal of the obstetrician a means of diagnosis of inestimable value. The employment of antiseptics has rendered possible manipulations for the diagnosis and treatment of labor that formerly were impracticable. Methods of diagnosis are now commonly taught and practised that, at the period mentioned, were only to be seen in practice in the large hospitals of Europe. Modern obstetrics has, then, great advantages in its opportunities to acquire thorough knowledge of the patient and of her labor, and this, too, without the infliction of additional pain, or the incurring of added risk to life. The characteristic of modern obstetrics is its scientific element, as shown in the accurate knowledge that it requires concerning matters formerly thought to prosper inevitably through the kind coöperation of Nature.

Scientific obstetrics is the rule in the modern hospital, but it is often "honored more in the breach than in the observance" in private practice. The reasons for this are many. First, among all, is the common belief, derived largely from physicians and

nurses, that, because labor is a natural process, it is bound to proceed successfully without intelligent supervision. If this is true, why should a patient tolerate palpation, auscultation, or pelvimetry ; or why should she take an anesthetic when the mechanism of labor is interrupted, and a thorough examination of the condition present becomes necessary ? A common belief that has descended from the days of the early craniotomist, or man-midwife, as he was termed, is that any interference with labor means, practically, the use of forceps, and hence the objection to critical examination in an emergency. Again, it not infrequently happens that a complicated labor terminates spontaneously, and apparently with success to mother and child. It does not occur to the patient and her friends that complications may have arisen, by reason of the long continuance of the spontaneous labor, that could have been avoided had intelligent interference been practised.

There is especial need for scientific obstetrics in private practice, because the practitioner is more directly responsible for the condition of his patient than when he is engaged in hospital practice. He lacks in private the experienced observation of trained nurses ; he misses the intelligent coöperation of resident physicians ; and experiences the great disadvantage that the absence of order and discipline, so common in a private house, entails upon him. It is, therefore, especially necessary that he gain thorough knowledge of his patient by personal observation and study, and this knowledge is the essential of scientific obstetrics. The fact that the

best results in obstetric practice are observed in hospitals, draws attention to the need for scientific work in private cases.

Omitting a consideration of the minor details of private obstetric practice, we urge the importance of a thorough examination by the practitioner of all pregnant patients. We are well aware of the fact that many cases are not seen by their attendants until labor is far advanced, and no opportunity has been given to examine the patient during pregnancy. This is growing to be, however, less the case than formerly, and especially in first pregnancies, when the natural dread of an untried experience brings the patient to the physician comparatively early. This scrutiny of the pregnant patient should be directed especially to ascertaining the condition of the organs of elimination, and the success attending their action. The examination of the urine should be an invariable practice, and valuable information will be given by ascertaining not only the presence or absence of albumin, but by careful microscopic study of the sediment, and also an estimation of the amount of urea excreted. In the Maternity Department of Jefferson Medical College Hospital we have for some time derived valuable information regarding a patient's eliminative powers by ascertaining the quantity of urea excreted. The presence of albumin is of itself a trifling matter, unless the microscope reveals evidence of decided structural change in the kidney.

At or after the seventh month of pregnancy it becomes the duty of the attending physician to ascertain the mother's size, and the relative size of

the fetus and the position that it occupies in the mother's pelvis. This is a procedure commonly thought unnecessary, and reserved for the lectures of those who teach obstetrics. That such is not the case is well exemplified by two fatal cases, seen by me recently in consultation, in both of which embryotomy upon the dead fetus was necessary. Two well-developed male children were sacrificed to a lack of diagnostic skill on the part of the medical attendant, and to complete the unfortunate history of those two cases, the lives of the mothers were lost on account of the stupid laziness of the physicians, who neglected to use antiseptic precautions during labor. In both cases the child had perished before the consultation, and the embryotomy was performed to spare the medical attendant from reproach and criticism for his failure to deliver the mother. These four lives could have been saved had proper precautions been taken.

The practice of general medicine, including obstetrics, in country towns or villages, often taxes to the utmost the skill and wisdom of the so-called "country doctor." As a result, he has a range of experience unknown to his city brother, and becomes by natural development more assured, self-reliant, and efficient. He is the man who, above all others, can appreciate the value of any method of practice that shall add to the positive knowledge he has of his patient. We do not ask him to provide himself with elaborate or costly pelvimeters, or instruments for diagnosis, but, as is our custom in lectures at the Philadelphia Polyclinic, we do urge upon the general practitioner a knowledge and practice of palpa-

tion, auscultation, and of such a method or methods of estimating the size of the mother's pelvis and the relative size of the fetus as may be within the scope of his possibilities. No student graduates from a well-appointed medical college who is not in the possession of this knowledge, and certainly the general practitioner already established cannot afford to be behind the recent graduate in his resources. The objections urged against the examination of pregnant patients, including the measurement of the pelvis, are based upon needless exposure of the patient, or rude and unskilful manipulation. We have yet to find a private patient, of whatever station in life, who offers the slightest objection when her physician asks that he be given an opportunity to acquire a knowledge that shall the better enable him to care for his patient, particularly if, by so doing, he subjects her to no exposure, nor to tedious and painful manipulation. The abdomen of the patient may remain covered by one thickness of cotton or linen, without in the least inconveniencing the physician, and medical students under my instruction are taught to make their examinations in this manner.

One of the great advantages accompanying this mode of practice is the lessening of vaginal examinations, which are a source of considerable danger to the patient. It is perfectly possible by palpation alone to follow the head of the child as it descends through the pelvic canal and impinges upon the pelvic floor. The character and efficiency of the pains of labor may also thus be accurately observed, and

oftentimes valuable assistance can be rendered by external pressure gently and judiciously applied.

When the mechanism of labor is interrupted, a thorough internal examination is at once indicated. This is often impracticable without the administration of an anesthetic. The practitioner should be prepared to interfere for the assistance of the patient. Forceps should be prepared and ready. The rectum and bladder should be emptied, and, while it is not necessary to state to the patient that an operation is to be performed, yet, while she is under the influence of the anesthetic, it may be found wise to terminate the labor. It is often impossible to accurately diagnosticate a faulty position of the head without an anesthetic, the resistance and suffering of the patient being so great that sufficient of the hand cannot be introduced to make a thorough examination. When, however, such an examination has been made, and before the examining hand has been withdrawn, the forceps may often be accurately applied to the sides of the child's head, and the labor brought to a successful termination. In other cases, version and extraction may be found necessary. In either event, examination of the patient under anesthesia will spare her hours of suffering, and will often save the life of an infant, and sometimes that of the mother.

The same thoroughness in treatment should obtain in the diagnosis and treatment of injuries to the genital tract. By the term "laceration of the perineum," we understand a solution of continuity that extends more deeply than the posterior commissure or fourchet. We are aware that a laceration in the

median line may extend beyond the fourchet, and still not impair the supports of the uterus to any appreciable degree. When we read and hear of large numbers of cases of labor in which no laceration of the perineum has occurred, we are impressed with the fact that those who record such extraordinary experiences either consider that a laceration of the perineum usually extends into the rectum, or else that they did not accurately examine the cases. The examiner may be readily deceived by a superficial examination by the finger only of the genital canal, soon after labor. Clotted blood often fills a torn surface, giving to the finger the same continuity of smoothness that marks the uninjured mucous membrane. It is only by the thumb and finger, one inserted in the rectum, or, better still, by actual inspection, that the condition of the genital tract after labor can be accurately ascertained. Considerable observation of labor-cases, and the careful employment of the best-known means for preventing laceration of the perineum, have convinced me beyond reasonable doubt that such an injury is inevitable in many cases. It is negligent not to discover it; it is lazy and dishonest not to endeavor to repair it.

Fortunately, in these matters, public sentiment is demanding the advantages of scientific obstetrics. We recently had occasion to tell a young woman that she had sustained a laceration of moderate extent that ought to be closed. She said that if such was the case, she earnestly desired that it be at once repaired, as her sister had suffered from the neglect of her physician in not suturing a similar laceration. We are furthermore helped in dealing

with these questions by the fact that experience shows us that excellent results may be obtained as late as twenty-four or thirty-six hours after the occurrence of a laceration. It is far better practice to give the patient and physician twenty-four hours' rest after a trying labor, and then, under anesthesia, or with the use of cocaine, close a laceration under favorable circumstances, than to further exhaust a weak patient, and with poor light and laboring under great fatigue, to improperly perform the physician's duty. If torn surfaces are found glazed over, the simple expedient of scraping them with the blade of a pair of scissors, or with a curet, will suffice to secure union by first intention.

It is burdening you with a trite observation to speak of the importance of obstetric antisepsis or asepsis, and yet the same reasoning that enables the practitioner to assert that in his 1000 cases he has never had a lacerated perineum, leads him likewise to claim that his 1000 cases he has never had a case of puerperal septic infection. He may have avoided signing a death certificate for a patient recently delivered, the certificate bearing the words "peritonitis," "blood-poisoning," "inflammation of the bowels," or "puerperal fever"; but cases occasionally perish some weeks after labor, with "jaundice," "pneumonia," "congestion of the liver," or "malaria," that, on closer study will be found to be the results of puerperal septic infection. The faithful practice of aseptic or antiseptic precautions greatly lightens the load of responsibility that the practitioner of obstetrics must carry.

Not the least of the advantages derived from the

scientific practice of obstetrics lies in the avoidance of interference by those who have no right to molest the patient. The practitioner's best efforts are often thwarted by ignorant and meddlesome persons. He cannot, however, honestly forbid interference, unless he knows positively that there is no occasion to molest the patient. He will obtain the best results in obstetric practice who does the work himself, unless he can command, for certain things, the assistance of a trained nurse. Thoroughness in diagnosis, the faithful observance of antiseptics in treatment, and the protection of his patient from meddlesome interference, will give the best results. Such a method of procedure is thoroughly scientific, for it demands the best knowledge, the most careful and skilful manipulation, and, above all, an honest and fearless attempt to meet the difficulties that may arise. In the present stage of medical science, every woman has a right to demand such treatment, and if a practitioner of medicine cannot give his patient such care, he must inevitably, by the inexorable law of the "survival of the fittest," give place to those who can.

The Medical News.

Established in 1843.

A WEEKLY MEDICAL NEWSPAPER.

Subscription, \$4.00 per Annum.

The American Journal

OF THE

Medical Sciences.

Established in 1820

A MONTHLY MEDICAL MAGAZINE.

Subscription, \$4.00 per Annum.

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